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DESTRUCTION OF THE QUARANTINE STATION
(Courtesy of George H. Doran Company)

Medical

THE NEW YORK
ACADEMY OF MEDICINE

VOL. II JANUARY, 1926 No 1

THE DESTRUCTION OF THE QUARANTINE STATION ON STATEN ISLAND IN 1858

As far as known, the reactions of humanity to the impact of epidemic diseases through the ages have been true to type, an expression of mental perturbation in the face of an overwhelming and seemingly undecipherable calamity. The incantations of the Assyro-Babylonians against the demons of disease fairly pulsate with this spirit of protest:[1] the rhythmus is that of some heaven-storming crescendo in a Beethoven or Tchaïkovsky symphony. In like manner, the Hebrews of the Old Testament attributed devastating epidemics to the wrath of Jahveh. The epidemic of dysentery, which assailed the Grecian hosts in the second Iliad, was attributed to the wrath of Apollo, to be propitiated by a sacrifice of beeves and of Trojan youths. In the Middle Ages, the Jews were persecuted for alleged poisoning of wells. During the great plague of Milan (1630), one Guglielmo Pazza was tortured, broken upon the wheel and burned for alleged dissemination of the pest by smearing the virus upon houses. In some Italian cities, a "column of infamy" (*colonna d'infamia*) was erected at the places where these unhappy victims of popular superstition met their fate. Up to the early 19th century, clergymen continually belabored their congregations with sermons on local or casual epidemics as "scourges of God for the sins of mankind" (Cotton Mather). Some of these sermons are in print and can be seen in medical libraries. The attack on the Quarantine Station on Staten Island on September

[1] On this head, see Fr. Lenormant: Chaldean Magic, London, 1877, *passim*.

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1–2, 1858,[2] like the Boston Tea Party or Concord Fight, was in no sense a manifestation of crowd psychology, but the deliberate procedure of a people singularly patient under abuses, but once aroused, apt to be swift, sharp and sudden in reprisals. Of the Americans of this period, the sardonic swindler in Martin Chuzzlewit observed, with a leer: "They do rile up and that's a fact."

The first quarantine establishment in New York State was located by Act of the Colonial Legislature on Bedloe's Island in 1758. In 1796, it was removed to Governor's (then Nutten) Island, but upon the appearance of yellow fever in nearby New York three years later, new measures had to be taken. In 1799, the State Legislature passed an act appointing commissioners to select a new site on Staten Island, appraise the lands seized for this purpose, and erect quarantine hospitals upon them. The inhabitants, through Mr. Micheau, their representative at Albany, strenuously opposed this bill and refused to sell their lands. Nevertheless, the appointed Commissioners proceeded to select and assess damages for some 30 acres selected by them, for which they took a title in fee from the Church of St. Andrew, in the name of the People, by the right of eminent domain. The fat was now on the fire, and for over half a century thereafter (1799–1858) the history of this station is a continuous record of martyrisation of the inhabitants by epidemic diseases, set off by futile attempts at legal redress of grievances, baffled at every turn by the cool, steady wire-pulling of interested politicians, who were dead set upon retaining their perquisites and sinecures. In 1800, one year after the establishment of the station, yellow fever broke out among the sparse population living outside the quarantine area, and of the 25 cases, no less than 24 terminated fatally.

[2] The present account of this occurrence is derived from a pamphlet in the Library of the New York Academy of Medicine, entitled: "Facts and documents bearing upon the legal and moral questions connected with the recent destruction of the Quarantine buildings on Staten Island. By the Executive Committee of Staten Island." 90 pp. 8°. New York, Wm. C. Bryant & Co., 1858. The copy of this pamphlet in the Surgeon General's Library (Washington, D. C.) has been lost or mislaid. If any physician or bookseller can supply this missing item, the opportunity to purchase it will be much appreciated by the Librarian, Surgeon General's office.

This sort of thing went on, almost every year thereafter, up to 1848, when the extra-quarantine incidence was 180, with many fatal cases. Yielding to the pressure of repeated protests, the Legislature of 1848 appointed the usual Committee to examine into quarantine conditions, the result of which was an unanimous and elaborate report (1849) to the effect that the Quarantine Station afforded no real protection to New York or Brooklyn, was a menace to Staten Island and "an unjustifiable burden upon Richmond County," with a recommendation for its immediate removal. Meanwhile, yellow fever broke out again, ravaging the Island with unprecedented violence and spreading to nearby cities. The Legislature, therefore, ignored the determined opposition of the shipping interests, and on April 10, 1849, passed an "Act for the establishment of hospitals at Sandy Hook." But, through the subterranean hostility of interested parties, no definite action was ever taken, the expressed will of the people was defeated, and the law remained a dead letter on the statute book up to the events of 1858. In the summer of 1856, there was another frightful epidemic of yellow fever, numbering 538 cases around New York, of which 93 were on Staten Island, with a mortality of one third the total cases. As several distinguished citizens were victims, another Act was passed by the Legislature (on March 6, 1857) for the removal of the Quarantine Station, but the execution of this law was again baffled by the sinister influences still at work. At this time, through successive legislative enactments, the Health Officer is said to have been vested with more power than had ever been delegated to any other official in the State. In consequence, there was great corruption in the pratique of quarantine, with a view to increasing the graft of this official by monopolies connected with the lightering of cargoes, arbitrary retention of vessels and passengers at enormous expense and venal accordance of releases from pratique to those who paid well for the privilege. Quarantine had thus become a farce. Of actual segregation, there was little or none. Stevedores and passengers from suspected vessels were permitted to pass over to New York and Brooklyn by ferry or otherwise, and within the crowded quarantine grounds, the sick and well were always in dangerous proximity. All this was set

off by most virtuous claims of a rigorous enforcement of quarantine in the newspaper press, the old stereotyped humbuggery of *bonne mine au mauvais jeu.* To protect the lives of citizens, the Board of Health of Castleton made regulations and erected buildings to prevent intercourse between persons inside and outside the Quarantine enclosure. Under cover of similar regulations, the Health Officer actually connived at destruction of these barriers by mob violence, and procured the release of the offenders upon arrest, *via* writ of habeas corpus. The "Rattler," an infected vessel, which the Mayor of New York had driven from the harbor, was permitted to anchor near the ferry landing of Staten Island and many cases were traced to this and other laxities of administration. At length, the Board of Health of Castleton passed a resolution declaring the Quarantine Station to be an intolerable nuisance, and calling upon "the citizens of the county to abate it without delay." Thus matters stood at the end of August, 1858. On the nights of September 1 and 2, Ray Tompkins and John C. Thompson set fire to the Quarantine buildings and destroyed them. The patients had already been removed from the buildings before ignition, and were sheltered and cared for by physicians. The only person killed was shot by an employee of the Station. The culprits were duly arrested, charged with arson, tried, and released by decision of Judge Metcalfe on October 7. The summing up of the judge is a masterpiece of legal argumentation. It was shown from the evidence gathered by an appointed committee, and by the sworn testimony of many resident physicians, that the abuses endured by citizens of the Island for over 50 years were intolerable, that the destruction of the buildings was a virtual enforcement of the two thwarted acts of 1849 and 1857, that the resolutions of the Board of Health of Castleton were guarded and virtually authorized by the Session Laws of 1798 and 1850, and that apart from the broad legal principle, *Salus populi suprema lex,* there was abundant legal precedent to the effect that the commission of an "act of salutary and well-intentioned violence" implies exemption from responsibility "upon every ground of justice and of positive law." The prisoners were therefore released and Staten Island was at last relieved of the nuisance which had tormented and destroyed its citizens for over half a century.

At this time of day, it would be cheap and easy to descant upon the ignorance then obtaining as to the real cause of the trouble. It has been well said that we feel towards and think backwards: our hindsight is better than our foresight. The famous initial regulations for 30-day quarantine against plague at Ragusa (1377) and 40 days (*quaranta giorni*) at Marseilles (1383) and Venice (1403), failed through ignorance of the actual nature of carriers. But in 1858, all that was known of mosquito transmission of fevers was the intuitive feeling, which even the Romans had, that marshes, if not mosquitoes, had something to do with it. Lancisi (1707) and Nott, of Mobile (1848), had even written monographs on the subject, but the general theory of malarial infection was that of a vague "miasm" or vapor emanating from the swamps, and that the darkness of night was essential to its potency (J. K. Mitchell, 1849). In 1880, the late Col. J. S. Billings pointed out that the symptoms of yellow fever suggest an infection like that of snake-bite, that the cause may be an organism like the yeast plant, with a product like alcohol, that the disease always occurs near wharves, piers, ships and decaying buildings or refuse, that clouds of smoke from burning fomites are as the very wings of pestilence, that shaking of textiles in cold outside air will avail to disinfect them, and that there is much in the old farmer's adage: "Yellow fever can't get anywhere unless yer tote it." This was still a far cry from the demonstration of the actual vector of the disease by Walter Reed and the U. S. Army Board in 1900. In the light of these facts, the action of the citizens of Staten Island in 1858 needs no justification. As the late King Edward VII observed: "The Americans are a much enduring people."

F. H. Garrison

ANNIVERSARY DISCOURSE

THE DOCTOR AND THE CHANGING ORDER

(Abstract of an address by George E. Vincent, President of the Rockefeller Foundation, before the New York Academy of Medicine, November 19, 1925)

Individualists have been described as people who can not see the woods for the trees, and collectivists as folk for whom the forest obscures the single oaks, hemlocks and beeches. The former think of life in terms of personal aims, rights and duties; the latter seem to regard community or nation or mankind as great organic entities of which men and women are hardly more than constituent elements, cells in a social body. The individualist naturally believes in freedom of the will; the collectivist tends toward determinism. Each theory pushed to an extreme deals with an abstraction, on the one hand an isolated person, on the other an impersonal unity. Both views have value; they are ways of approach to the bewildering complexity of life; they help one to analyze and simplify.

Thus doctors may be looked at usefully either as individuals living their own personal lives, increasing their knowledge and power, demanding their rights, protecting their privileges, helping their fellows, or they may be regarded as servants of society, controlled, subordinated, even exploited for the common welfare. For obvious reasons doctors have been individualists. Until recently there has been no question of their being anything but independent and self-sufficient. Their services have been intimately personal. To them the world is quite obviously peopled by separate persons; no wonder the doctors see the trees instead of the forest.

Just because of this, it is a salutary thing for physicians now and then to contemplate themselves from the social point of view. Society is a useful abstraction, a symbol for the common life, the collective interests which seem to overshadow the individual, and even to use him for that other abstraction, the general good. For the purposes of this address society will be personified and credited with aims, purposes and plans. Even indi-

vidual ambitions, privileges and rights will be treated as means of social control. So much by way of fair warning.

Society in order to keep its many activities going must recruit its servants. Careers of many kinds are offered to youth. Only rarely is there resort to conscription. Enlistment is for the most part voluntary. This means that society must offer the inducements which will attract candidates, persuade them to prepare for a given kind of work and then keep them reasonably contented and efficient. It would be a mistake to suppose that society does this with any clear consciousness of what is going on. But in a somewhat hit or miss fashion the recruiting gets done.

What are the means by which society draws youths and maidens into the career of medicine? Sometimes family tradition can be utilized, but these are the standard inducements: prestige and social esteem; access to sound training; consciousness of knowledge and skill; adequate income with provisions for old age; a sense of initiative and freedom; recognition for adding to the sum of science and technique; protection against the competition of incompetent or unscrupulous physicians and of charlatans and fanatics; a feeling of professional comradeship and loyalty; an idealism which gives high, human significance to the doctor's part in the social order.

Societies vary widely in the actual validity of these items of appeal. Sometimes doctors think that they are the victims of false representations. So, too, the character of a medical profession is determined by the relative emphasis which society puts upon the different inducements. In a community which sets great store by wealth even medical success is likely to be measured by economic status. Perhaps this is inevitable because the same society is appealing at the same time for recruits for many other professions and vocations. The best ability flows to the careers which society makes on the whole the most attractive.

The promises and rewards which society holds out to doctors have a selective effect. They appeal differently to different capacities and ambitions. In this way types are created. Some men prefer the laboratory to the limousine; others are drawn to salaried posts in institutional services; still others are lured by the high adventure of surgery; the many find their best reward

in skilled and sympathetic daily care of sick people; not a few are turning to the task of protecting individuals and groups against disease.

After society has caught and trained its doctors it expects certain things from them; professional competence, for example. It calls upon them to keep up with the growth of knowledge and the increase of skill, to have access to useful means of finding out what's wrong with a sick person and of helping to set it right. Society counts also on getting sound advice about personal hygiene; it looks to doctors for understanding, individual attention and a genuinely human sympathy. It asks for a finer spirit than it requires of any of its servants, with the sole exception of its religious leaders.

So long as society led the simple life of countryside, village and small town with diversified agriculture, cottage industries, local markets, slow transport, leisurely spread of news, and so long as each doctor knew almost all there was to know of medicine and its arts, the relation of physicians to their communities presented few problems. Like the lawyer, merchant, and school teacher, the doctor was an individualist, a self sufficient, independent unit in close and neighborly contact with his patients.

But society no sooner settles down to a routine of custom and habit than something happens. A conqueror invades the land, or more disturbing still, someone has a new upheaving idea which can not be suppressed. Then the game of adjustment begins all over again. In prosperous, pioneer lands this is called progress; in older, disillusioned societies people are not sure that it is anything more than change. But whether it be headed straight for a millenium, or started on a slowly recurring spiral, or only doing another lap on a vicious circle, it disturbs the peace, raises problems and worst of all compels a few people to think, or at least to "rearrange their prejudices."

The men who invented steam engines, spinning jennies, power looms, cotton gins, railways, ocean liners; their successors who applied electricity and devised internal combustion engines simply played havoc with the good old times. To be sure the natural philosophers were at the bottom of the mischief with their discoveries in mechanics, chemistry and electricity. The medical

scientists, by accumulating stores of new knowledge and making exciting discoveries, also helped to bring in and complicate a new order.

To describe in any detail the present state of society would be merely to offer what *Punch* calls "glimpses of the obvious." A chiefly urban, minutely specialized and highly interdependent, industrial, commercial and social system made up of many groups of varying economic status, racial origins, education and religion confronts the modern doctor with new problems. His former individualistic neighbors, the merchant, banker, manufacturer, even lawyer and teacher, have been drawn into organizations and have largely lost their independence as self-sufficing units. Must the doctor, who can now master only a part of the vast total of medical knowledge and skill, follow in their footsteps?

The first impulse is to protest against the idea that medicine is a mechanical process, or a business, that it can be organized like a factory or a department store. To suggest such a thing is, it would seem, to ignore the personal, individual relationship which is a condition of genuinely effective medical care and counsel. It is this very conflict between the call for team-work on the one hand and the demand for human insight and sympathy on the other that creates a perplexing problem.

But, it may be asked, is there, as a matter of fact, a need for closer co-operation among doctors? Which may be answered by another query: Can they escape the law of specialization and integration which Herbert Spencer elaborated so remorselessly in his ponderous polysyllables?

It is at this point that the familiar procession of facts should pass across the scene: the enormous increase in scientific knowledge and in technical skill, the inevitable dividing up of these resources, the entrance of the consultant, the development of hospitals, dispensaries, and diagnostic laboratories, the appearance of group medicine, the opening of pay clinics, the growth of industrial medical services, the progress of public health with its salaried officers and nurses, foreign systems of health insurance, and here and there the shameless rise of actual state medicine. It is estimated that five million patients receive attention yearly in the dispensaries of the United States.

Society has, it seems, been asking for things from the doctors; closer co-operation in focusing specialized knowledge and skill on the sick individual, more economical common use of facilities, some better way of distributing the burden of sickness costs over large numbers of individuals or families, and loyal aid in protecting whole groups from disease. For the rich and well-to-do and for the very poor in large towns and cities society has managed not too badly, but for self-respecting folk of moderate or limited means the job has so far been pretty generally bungled.

The pageant of progress reviewed above may easily be misinterpreted so far as organization of medical service goes. Nearly ten per cent. of the active doctors of the United States are full-time salaried officers in army, navy, public health services, industrial establishments and public institutions. Only to a limited extent do they work as groups. For the most part they are individual practitioners. Much of the service of dispensaries, especially of the smaller ones, is carried on by doctors who work almost independently.

Although the sick benefits of lodges, benevolent orders, labor unions, the voluntary health insurance schemes of Denmark and Norway and the compulsory systems of Germany and Great Britain cover very large groups of people, the medical service is rendered by contract or panel doctors, the vast majority of whom are general practitioners working in their own offices. There is little or nothing in the form of clinics. The medical care is probably on the whole inadequate and certainly unorganized. Commercial insurance companies which issue policies against sickness do not for obvious reasons offer organized medical service to their patrons. These persons resort to practitioners of their own choosing.

Only, then, in university clinics, in well-developed hospitals, dispensaries and pay clinics, in true group practice, in health centers, is there to be found genuinely organized medicine, *i.e.*, the team-work of skillful diagnosticians with well-trained specialists backed by efficient laboratory, operating and treatment facilities. However, with respect to these agencies serious question is raised. Are they not mechanizing medicine, eliminating the personal factor and the human relation?

Much the same query has been made about schools and universities. Have not the virtues of the little red school house and the small arts college been all but lost in our modern organized, graded, highly equipped instruction machines? Perhaps; but no one proposes to restore the one-room rural school or even Mark Hopkins' log. The plea is for smaller classes and closer relations between teacher and pupils. The specialization and organization are accepted as unescapable consequences of social changes.

As society notes what is going on, it is reminded now and then that the new ways of doing things may affect the recruiting for the career of medicine. If the attractions already enumerated are radically lowered may not the best abilities hesitate—even turn to other vocations? The hospital associations of Cuba offer an illustration. Nearly a quarter million of individuals contribute a dollar and a half or two dollars a month to five societies which in return guarantee medical attention and, if need be, unlimited care in large modern hospitals equipped with every facility for diagnosis and treatment, and manned by specialized staffs. Society seems to have managed this well. Costs are distributed so that no one individual bears a crippling or even serious burden. If he falls ill he is sure of excellent care.

But can he count on this same quality of service for his children and grandchildren? The Cuban doctors complain that the hospital associations drive hard bargains. They so nearly monopolize the best paying part of the population that, with the exception of a few outstanding specialists, no capable and ambitious medical man can maintain himself independently. He is forced to accept a full or part-time salaried post. The scale of pay is not high. No special allowances are made for advanced study abroad; research is not signally distinguished. The doctor's sense of initiative and freedom is narrowed. Will the best young Cubans go in for medical careers in these circumstances? If they do not, society will in time, perhaps, modify the conditions, increasing the attractions and removing the obstacles. Who knows?

Such organization of medicine as has begun to appear is found almost always only in large cities and big towns. The smaller town and village hospitals are little more than houses in which

individual doctors care for their private patients and carry a part of the free service for the sick poor. There is, to be sure, a little specialization, too often of a rather superficial sort, but almost no team-work worthy of the name. Even in the large cities only a small part of the profession is really related to hospital, dispensary and other grouped staffs. In the country at large individualism and independence prevail. In village and countryside the isolated practitioner is the only resident type. So there is no stampede for organization in medicine.

The allusion to the rural doctor had to be. No address on medical organization can leave him unnoticed. What will society do to keep him on the job? Give him a cheaper and shorter training? Sound the slogan: "Poor doctors for poor people?" Subsidize him with free office room and an annual retainer? Or try to make farming and rural life more attractive not only to the doctor but to the farmer and his family? For, after all, medical care and protection of health is only a part of a much bigger thing, the whole agricultural question.

Or is organization going gradually to invade the countryside, set up visiting nurses as medical outposts with first aid stations based on staffed hospitals in the nearest towns which in turn will call on regional medical centers in cities small or large? Good roads and motor cars have made a radical difference. Has not the doctor's call and ambulance radius been enormously increased? And now the public motor snow plow makes its debut. The unfortunate rural doctors of the North will soon find that even snow drifts are no longer a protection against the enterprise of their urban colleagues. But all this seems rather too systematic and comprehensive. Society shies at schemes so academic. Muddling through is much easier and safer than making far-reaching plans on a grand scale.

Nor can the general practitioner be denied a paragraph in this interrogatory discourse. His gradual disappearance has been predicted. "How", it is asked, "can he survive if prestige and emoluments are going to the specialists, if sanitarians and hygienists keep cutting down the output of patients, if free and pay clinics offer the competition of organized service, if hospital connections continue to be limited and elusive, if the public fails

to discriminate between fairly well-trained men and obscurantist healers?'' The outlook may not seem too bright but, as we have seen, the family doctor is still the overwhelmingly prevalent type both in city and country. He may not be keen about going into rural practice, but there seems to be life in the old boy yet.

Who knows? Society may gradually induce him to shift his attitude. Perhaps he will get connections with diagnostic centers, group himself with fellow doctors about common laboratory and treatment facilities, go in for keeping people well through health examinations and advice about personal hygiene—in short, get himself more organically related to society's medical services and come to think of prevention more than of cure. But this begins to have a familiar sound. The main point is this: Society has been some time making the general practitioner, has found him highly useful and is not likely to give him up if he can be gradually modified somewhat to fit new demands.

But this talk about society may be getting wearisome. What is this potent entity? Has it the capacity to appreciate science, to maintain discriminating standards, to recognize and follow genuine experts, or is it credulous, careless and easily misled? Is there any truth in the cynical assertions that democracy is ''the cult of incompetence,'' ''the passionate pursuit of the second-rate?'' Well, society is only another name for all of us. Each of us finds within him the mythical ''average man,'' and can hazard an answer on his own account.

There are, it is true, plenty of discouraging things that come to mind. But who will say that we shall not in time extend our present rational confidence in physicists, chemists and engineers to include biologists, medical laboratory scientists, clinicians, sanitarians and hygienists, and, what is more, be guided by them in our ways of life and conduct? The Hollanders and the Scandinavians, to mention only the more conspicuous, have set reassuring examples. Signs of progress are not lacking in our own land, in spite of the prevalence of quack remedies, and the existence of ignorant or unscrupulous doctors, embattled anti-vaccinationists, quaint deniers of disease, wonder-working healers and erudite foes of evolution.

As a Broadway play must have a happy ending, so an American address must close upon a helpful, hopeful note, no matter

what the baffling complexity of the subject or the calamitous incompetence of the speaker. It is not easy to violate an established tradition. One is almost tempted to fall back upon the panacea for all our ills and reaffirm confidence in Education. But the easy way must be avoided.

"The old order changeth." That is a law of life. To this changing order all, even doctors, must adapt themselves. And this adaptation takes place not through large, comprehensive, elaborate schemes of reform but by piecemeal, here and there, now and then, by happy chance, by trial and error, opportunistically, unconsciously. Academies of medicine can do something, but probably not much. The larger the number of minds that see the trend of things, the better the chances of gradual adjustment. So studies, comparisons of experience, experiments, demonstrations, discussion, all play a part and are to be welcomed.

To sum up: It looks as if society means to insist upon a more efficient organization of medical service for all groups of people, upon distribution of the costs of sickness over large numbers of families and individuals, and upon making prevention of disease a controlling purpose. Just how these ends will be gained only a very wise or very foolish man would venture to predict. One thing seems fairly certain: In the end society will have its way.

PRESENT STATUS OF CHRONIC CHOLECYSTIC DISEASE AND PRACTICAL ASPECTS OF STUDIES IN HEPATIC FUNCTION

(Abstract)

GEO. B. EUSTERMAN

MAYO CLINIC, ROCHESTER, MINN.

(Delivered before the New York Academy of Medicine, December 3, 1925)

PART I

CHRONIC CHOLECYSTIC DISEASE

(a) Etiology.—(1) The infectious or inflammatory theory enunciated by Naunyn. A local inflammation of the gallbladder

wall leads to an increased formation of cholesterol by the lining epithelium; the liberated cholesterol is cemented together by bilirubin calcium. Probable causative factor of excess concentration of bile, stasis and infection. Researches of Graham and Peterman cited in the etiology of cholecystitis and hepatitis:—infections of the alimentary canal, especially with virulent bacillus coli. These organisms are carried to the liver by the portal vein, are excreted into the bile and then by lymphatic extension to the liver (local hepatitis), gallbladder, pancreas, often to the duodenum and stomach. Causative rôle of an antecedent appendicitis. Cholecystitis may result from microorganisms invading the organ through the blood stream. Streptococci from infected tonsillar crypts or periapical abscesses, and selective affinity theory of Rosenow. Enteric fever (typhoid and paratyphoid, A, B and C) formerly held a high place in the etiology of cholecystitis and gall-stones. Reaction against this view due to progressive decrease of enteric fever in contrast to a real or apparent increase, or more frequent recognition of gallbladder disease. However, in the opinion of the writer, with a reliable history of an antecedent typhoid or paratyphoid fever, especially the former, the possibility of chronic cholecystic disease must be ruled out in any upper abdominal complaint. The puerperal state and gallbladder disease. Tonsillar sepsis, appendicitis, rheumatic fever, lagrippe and influenza seemed to play a causative rôle in acute and chronic calculous and non-calculous cholecystitis in a series of 175 young individuals. Typhoid fever infrequent in this group.

(2) The biochemical or metabolic theory. There is an increase in the cholesterol content of the blood and therefore in the bile and thus pure cholesterol calculi produced (Aschoff and Bacmeister). Presence of such aseptic calculi may cause secondary infection and thus be indirectly responsible for the commoner calculi. The experiments of Rous, McMasters and Drury in the aseptic production of showers of small calculi composed of organic debris and calcium carbonate and calcium bilirubinate in sterile bile was cited. Hereditary and racial factors in cholecystic disease. Rolleston believes that both etiologic factors of gall-stones, the infective and the metabolic, sometimes one alone, probably more often both together, are operative.

(b) Incidence and sex ratio.—In our experience the commonest cause of chronic recurrent painful dyspepsia in the middle aged. More frequent than gastro-duodenal ulcer and gastric cancer combined. (Sixty per cent. more frequent than gastric and duodenal ulcer combined.) Fifteen per cent. of the latter have associated gross, demonstrable disease of the gallbladder at operation. In 9,115 patients with gall-stones surgically verified, 24 per cent. were males and 76 per cent. females. In 4,978 patients with acute and chronic non-calculous cholecystitis, 28 per cent. were males and 72 per cent. females. The sex ratio in children and young adults was about equal.

(c) Symptomatology.—Chiefly discussed under next heading. Factor of complications such as duct stones, strictured duct, empyema, cholangitis, pancreatitis, carcinomatous transformation, hypertrophic biliary cirrhosis, perforation, etc.

(d) Clinical types.—Mild and latent cases. The remote forgotten or overlooked colic. Description of typical form. Pleurisy and ulcer types; chronic indigestion type; this may be erroneously interpreted as ulcer in the absence of colic or icterus, just as a perforating ulcer may be looked upon as a gall-stone case. Cancer simulation in advanced cholecystic disease. Discussion of the rarer crisis, left-sided, nervous and infectious types.

(e) Differential diagnosis.—Discussion of the commoner diseases, or intra-abdonimal lesions simulating the symptoms of disease of the gallbladder and its complications, with special reference to distinguishing features. Painful, penetrating or perforated ulcer, cardiospasm, tabes, hydronephrosis right kidney, renal stone, certain types of gastric neurosis, epigastric hernia, angina pectoris or angina abdominis, abdominal migraine, diaphragmatic hernia, angioneurotic edema, lead colic, irritable colon and diverticulosis, chronic pancreatitis, etc. Differential diagnostic factor of expert fluoroscopy of stomach and duodenum and hospital observation in obscure or difficult cases.

(f) Diagnostic procedure.—Comparative rôle of anamnesis, physical examination, biliary drainage and cholecystography discussed.

Part II

HEPATIC FUNCTIONAL TESTS

(The major portion of this theme, including preoperative and post-operative treatment of jaundiced patients, and Novasurol in the treatment of the cirrhoses complicated by ascites, was discussed from lantern slides.)

(a) Jaundice and its clinical aspects.—1. Types. (a) Obstructive, or biliary; (b) toxic and infectious, or hepatogenous; (c) hemolytic or hematogenous; (d) rarely mixed types in the same individual.

2. Problem of differential diagnosis of jaundiced patient, especially at middle age or thereafter. This is yet dependent primarily on time-honored history, physical examination, the simpler tests of blood, feces and urine for bile pigment and its derivatives, etc. The liver-spleen syndromes. Serum bilirubin estimation can differentiate between hemolytic and obstructive jaundice. Exceptions to this rule are the mixed types. Determination of the presence and amount of bile flow by duodenal intubation in the presence of an enlarged liver may distinguish between a hepatogenous and an obstructive jaundice. Differentiation of a catarrhal jaundice from that of a mechanical icterus such as that due to carcinoma at the head of the pancreas or bile ducts by urobiligen estimation (Wallace and Diamond).

(b) Tests based on metabolic function of liver.—These were disappointing due to the large factor of safety in the liver. Tests based on excretory function of the liver more successful. The metabolic activities of the liver not so readily disturbed and thus not so important in clinical medicine. Disturbances in bile formation and excretion are the ones we have concerned ourselves with most so far. Problem of metabolism of bile pigment practically solved. That of bile salts awaits solution. All "Gall" divided into three parts: pigment, bile salts and cholesterol.

(c) Dissociate jaundice.—Definition. Rôle of bile salts. Brule and hemoconia test. Our experience covers some thirty cases. Illustrative case report. Development in the Clinic of a new test for quantitative measurement of the bile salts in the blood serum proving satisfactory. Some patients showed an increase of six to seven times above the normal.

(d) *Van den Bergh test.*—A quantitative and sensitive one. Makes it possible to study bilirubin content of the blood serum in jaundiced patients. The test may be likened to that of blood urea in nephritis. In all cases the appearance of clinical signs of icterus follows the increase in the pigment content of the blood. Study of serum bilirubin has the following clinical usefulness:—(1) in estimating the degree of retention of bile in patients with obstructive jaundice; (2) in furnishing a quantitative index for the degree of jaundice observed in the various toxic or infectious types; (3) in following the course of jaundice due to any cause, and (4) in demonstrating the presence of latent icterus. In connection with latent icterus, a number of concrete diagnostic applications may be mentioned. In pneumonia, exophthalmic goiter, the toxemias of pregnancy, or following the administration of chloroform or arsphenamin, high bilirubin values predict the onset of toxic icterus with its important prognostic import. In heart disease, emphysema or arterial hypertension, rising levels of serum bilirubin foreshadow passive congestion of the liver as the result of myocardial failure. In secondary anemias, except those of hemolytic origin, normal bilirubin values are the rule. For example, in differentiating occult carcinoma and pernicious anemia, a high figure would argue for the latter diagnosis provided metastasis to the liver could be excluded. However, in the presence of carcinoma, elevation of the bilirubin value indicates involvement of the liver or biliary passages.

Determinations of the serum bilirubin are most valuable in the differential diagnosis of cases of abdominal colic. As pointed out by Blalock, less than a third of all biliary colic is followed by manifest icterus. In the remainder, not associated with jaundice, diagnosis may be extremely difficult. Following biliary colic, the serum bilirubin is elevated, although not always to a degree or for a length of time sufficient to color the skin or sclerotics. In such cases, the demonstration of latent icterus is diagnostic. We have also seen a few acute cases of severe but unlocalized abdominal pain, in which the finding of serum bilirubin in amounts considerably above the normal has served to establish the diagnosis.

(e) The phenoltetrachlorphthalein dye test.—This is of greatest clinical value in those cases of hepatic disease in which jaundice is not present. Historical and technic. Bromsulphalein. Obstetricians have applied the test in the differentiation of the toxemia of pregnancy from neurotic vomiting and eclampsia of nephritic origin. In the toxemia, the dye test will apparently indicate heaptic changes before the increase in serum bilirubin is established. In carcinoma of the gastro-intestinal tract, normal readings are obtained before extension of the growth begins. Moderate retention was found in a series of cases of carcinoma of the stomach or colon without jaundice and the surgeon found obvious metastasis to the liver in most of them. The degree of retention of the dye depends, in part, on the extent of the malignant process in the liver, so that a normal test will not positively exclude the presence of small metastatic nodules there.

Definite changes can be shown in cirrhosis by means of the dye test, although the correlation of laboratory findings with the clinical picture must be made with care. The retention of dye has definite diagnostic value in biliary, syphilitic or portal cirrhosis.

In ascites it is particularly of value to distinguish between ascites of hepatic origin and that due to ovarian cyst. In splenic anemia the dye test may distinguish between those with Banti's and those without much involvement of the liver. A negative response will not exclude disease of the liver however. In patients with a dye retention of Grade II or more a cholecystogram should be interpreted with care. In such cases an abnormal response may mean that the dye has not passed out into the bile.

"The various functional tests contribute but little from the standpoint of the differential diagnosis of hepatic diseases. This, perhaps, is to be expected, for experience with tests of renal function has likewise demonstrated that functional changes are not necessarily characteristic of the particular etiologic agent.

"The liver is an organ with a large factor of safety, for a large proportion of it can be removed experimentally and the remnant will still suffice for normal function. Again, disturbance in one type of physiologic activity does not necessarily indicate com-

mensurate disturbance in other functions of the liver. The presence of a normal amount of bilirubin in the serum and the absence of dye retention will not exclude hepatic disease. Positive tests, on the other hand, are of great value in indicating the probable presence of definite and widespread hepatic damage. Although the present hepatic functional tests are not ideal, their introduction is another milestone on the road to the better understanding of diseases of the liver."

END RESULTS OF TONSILLECTOMY WITH SPECIAL REFERENCE TO THE LEGAL RESPONSIBILITY

THOMAS J. HARRIS

(Delivered before the New York Academy of Medicine, December 17, 1925)

Abstract

The operation of tonsillectomy at the present time is much to the fore. Its seriousness has been minimized to such an extent that the general practitioner regards himself competent to perform it. The inevitable consequences are that among the innumerable operations performed many bad results have taken place and many accounts of damage suits at present are current. The purpose of this discussion is to ascertain just what the grounds for these actions have been and to know what legal rights and responsibilities a surgeon has in performing this operation. A questionnaire was sent out to one thousand laryngologists inquiring about all suits threatened or begun of which they were aware. Replies were received for the most part from trained operators and so are not an entirely accurate criterion, but a sufficient number was received from all parts of the country to warrant a careful analysis and drawing certain conclusions. Of one hundred and twenty-four cases threatened or instituted only four were decided in favor of the plaintiff; fifteen were decided in favor of the defendant. The grounds for action included, negligence or carelessness during or subsequent to operation, twenty-five; post operative hemorrhage, nine; lung

abscess, five; breaking of needle, one; anaesthesia, thirteen; operating without permission, five; death due to operation, thirty-one; operating during or too soon after diphtheria, four; removal and sloughing of palate, twelve; removal of uvula, sixteen; removal or contraction of pillars, eight; teeth knocked out, five; death due to operation, thirty-one; loss of singing voice and speaking voice, four.

Cases occurring in New York State, fifteen; cases dismissed by judge, twelve; cases settled out of court, twenty-four; cases that came to trial and later appealed, five.

Judicial opinions are handed down only in appealed cases. Of these the number is few, only five. The opinions in three of these are of particular interest. In the first case, the higher court sustained the findings of the lower court in declaring that it was within the judgment of a surgeon to select the form of anaesthetic, local or general, which he thought best in a given case. In the second case, one for negligence in cutting the tongue during the operation, the higher court held that carelessness and negligence in performing the operation was a just cause for action. The third case, in which a causal connection was claimed between certain physical ailments and loss of uvula during the operation, the higher court sustained the findings of the jury in favor of the plaintiff as far as the resulting injury and damages were concerned.

The one outstanding principle in malpractice suits recognized by courts in all states is forcibly illustrated in four cases decided in favor of the plaintiff, namely, that want of ordinary and reasonable care leading to a bad result is legitimate ground for action. The following deductions seem warrantable:

I. The number of malpractice suits in the eastern states at least does not appear to be at all in proportion to the total number of tonsil operations.

II. The actual number undoubtedly is on the increase. This is due in part to the greatly increased number of operations and in part to the incompetency of the operator.

III. The bringing of such suits is dependent in most instances on injudicious criticism of brother practitioners or on efforts of commercial lawyers.

IV. Almost every conceivable ground for action has been employed but not one of these per se renders the operator liable to action. All depend on the single question, did he exercise reasonable care and skill in the operation and after care.

The surgeon must constantly recognize his potential liability. He is at liberty to operate wherever he may choose, but the operation is a capital one and whenever possible should be performed in a well equipped hospital.

The want of ordinary and reasonable care leading to a bad result is the most common of all grounds for action. To establish this, testimony of an expert witness is necessary. Most bad results are due to incompetency on the part of the operator. There is a pressing need for the public to be educated upon the importance of the tonsil operation and of the necessity of this being performed by a competent operator. The largest step in this direction is the recent organizing of the American Board of Oto-Laryngology, composed of representatives of the four national societies specializing in these subjects, which passes on the qualifications of candidates and when satisfied of their competency, awards a certificate of approval. General support of this movement by all the credited laryngologists will greatly assist in discarding the so-called "six weeks specialists." In spite of the fortunate experience of most of us in never having been annoyed by a malpractice suit, it is possible for it to occur to anyone even after the greatest care has been exercised. On that account the defense work done by the several state societies and especially that of our own state society is deserving of the heartiest commendation.

PROPOSED CHANGES IN THE CONSTITUTION AND BY-LAWS OF THE NEW YORK ACADEMY OF MEDICINE

The development of the work of the Academy during the last twenty years has indicated the necessity of altering and clarifying many of the provisions of the Constitution and By-Laws.

During the winter of 1924, the Council appointed a special committee on Constitution and By-Laws consisting of Dr. Herbert S. Carter, Chairman, Dr. John A. Hartwell, Dr. Royal S. Haynes, Dr. Fenwick Beekman and the Director.

This Committee has reported and recommended a number of changes. Those changes which refer to the work of the various committees in the Academy have been referred to the respective committees and have been studied and criticized and finally approved by them. The changes have also been discussed in detail at two meetings of the Council and were transmitted to the Fellows of the Academy at the Stated Meeting of December 3 for consideration.

The proposed changes in the Constitution are as follows:

Articles I and II are changed as to wording and there has been added as one of the objects of the Academy the promotion of medical education.

In regard to qualifications for Fellowship, it is proposed that citizenship of the United States be no longer required, that medical officers of the United States Army, Navy, and Public Health Service may be elected to Fellowship, without the payment of an admission fee.

It is proposed that Resident Fellowship shall include those who live within twenty-five miles of New York City Hall.

It is proposed that the number of Resident Fellows be increased by fifty and if the amendment to the Constitution is adopted, that Resident Fellowship shall include all those who live within twenty-five miles of New York City Hall, that all those who are now Non-Resident Fellows within this area shall become Resident Fellows and that the number of Fellows be increased by one hundred and seventy-five instead of fifty (there are at the present time one hundred and fifteen Non-Resident Fellows living within twenty-five miles of City Hall).

It is proposed that candidates for Associate Fellowship must be graduates of at least five years standing and that dentists, pharmacists and scientists if actively engaged in teaching or research are eligible for Associate Fellowship.

It is proposed that there shall be a Committee on Public Health Relations and a Committee on Medical Education and provision

for their appointment. The Committee on Public Health Relations is a more descriptive name for the work which is being done by the Public Health Committee. This Committee came into existence in April, 1911, after the Section on Public Health was abolished and was replaced by a committee of the Council, then known as the Committee on Public Health, Hospitals and Municipal Budget. In January, 1915, the Academy by a formal vote granted to the Public Health Committee certain powers and privileges. The same powers and privileges have been granted to the Committee on Medical Education in 1925, and these have been incorporated in the new By-Laws of the Academy.

The present Constitution provides that the Academy may reprimand, suspend or expel a Fellow, but the present By-Laws provide that the Council may reprimand or suspend a Fellow. It is proposed that the Council may reprimand or suspend, and that the Academy may expel.

The proposed changes in the By-Laws are as follows:

It is proposed that the order of business for stated meetings of the Academy shall be defined and all references to meetings of the Academy which in the present By-Laws occur under three different articles be consolidated in one.

It is proposed that the wording in regard to the Vice-Presidents be changed so that instead of making it the duty of one of the Vice-Presidents to assist the President when requested, it shall be one of the duties of the Vice-Presidents.

The duties of the Historical Secretary and Corresponding Secretary are limited as the major number of their duties are now carried on by the administrative office of the Academy, and it is suggested that the offices be abolished.

Provision is made for the appointment of a Director by the Council and his duties defined.

Committee on Admission—The proposed changes in the By-Laws specify that applications for Fellowship shall be made by a Fellow only, acting as sponsor for the candidate, and require the submission not only of evidence of graduation but also qualifications for practice and other facts relating to his hospital, laboratory and teaching connections.

The qualifications for Associate Fellowship are raised by requiring at least five years standing and the proposed change

makes eligible those who are actively engaged in scientific research or in teaching in subjects allied to medicine without including the words "other than medical, dental or pharmaceutical."

It is also suggested that a new section be inserted providing that whenever a candidate shall have been before the Committee for a period of eighteen months and no action taken, the name will be removed from the list and his sponsor notified by the Secretary of the Committee on Admission, but that such action will in no way prevent a re-application being made for such candidate.

Committee on Library—There are few changes proposed except that more authority is placed upon the Librarian and that the wording is generally clarified.

Committee on Public Health Relations—The new Article on the Public Health Relations Committee provides for a Committee of thirty members, one of whom shall be a representative of the Medical Society of the County of New York, to be appointed by the President to serve one year and grants the Academy's present authority to the Committee to make studies and issue statements and to appear before committees, boards, legislative or other bodies in order to make statements or express opinions on matters relating to public health and hospitals, with the approval of three-fourths of the Committee and the President of the Academy.

Committee on Medical Education—The Article on the Committee on Medical Education provides for a Committee of thirty members, one of whom shall represent the Medical Society of the County of New York, to be appointed by the President to serve one year and authorizes it to maintain a Bureau of Clinical Information and to publish descriptive matter relating to post graduate instruction in medicine and allied subjects in this country and abroad.

Scientific Sections—It is proposed that the election of officers shall be held in May instead of in December so that programs for the winter session may be prepared by the newly elected secretary, that the Treasurer act as treasurer of the sections and that the Academy send out section notices.

It is also proposed that the secretary of each section shall furnish the editor of the Bulletin with an abstract of each paper read at the section meetings and the Recording Secretary shall furnish the editor with abstracts of papers read at the stated meetings for publication in the Bulletin.

Dues and Fees—The article on Admission Fee and Dues provides that medical officers of the United States Army, Navy and Public Health Service may be elected Fellows without the payment of admission fees.

It is also proposed that a graduate of a medical school devoting full time to teaching or research may have his admission fee waived and his dues fixed at five dollars a year, but that such Fellows shall have no right in the property of the Academy, and if at any time such a Fellow shall take up the regular practice of medicine, he shall pay the admission fee and the regular dues of Fellows.

It is also suggested that dues for newly elected Fellows shall be pro-rated quarterly—that is, a Fellow elected in the last quarter of the year shall pay the dues for that quarter only.

It also provides that a Fellow may resign within one month of the mailing of bills for dues, provided all other indebtedness is paid.

PUBLIC HEALTH COMMITTEE

CONSOLIDATION OF MUNICIPAL HOSPITALS

Municipal hospital development in this city originated with poor relief. The hospitals evolved under the aegis of the overseers of the poor. The first differentiation took place in 1875, when responsibility for hospitalization of contagious disease cases, which hitherto devolved upon the Commissioners of Charities and Correction, was transferred to the then youthful Department of Health. The Department of Health now has jurisdiction over five hospitals, the Riverside Hospital, Willard Parker Hospital, Kingston Avenue Hospital and the Queensboro Hospital, and also the tuberculosis sanatorium at Otisville. Some of the problems with which these hospitals deal are different from those of the ordinary hospital. They constitute a part, as it were, of the

machinery the city maintains to fight infectious diseases and are intimately associated with the work of the Bureaus of Preventable Diseases and of Laboratories of the Department of Health.

It was not until 1902, five years after the consolidation of Greater New York, that the second phase of differentiation took place. In that year Bellevue and several other municipal hospitals in Manhattan were by charter provision removed from the jurisdiction of the Department of Charities and placed under a board of trustees appointed by the mayor from lists submitted to him by several charity associations of the city. The action was taken with a view of inaugurating a system of hospital control free from political interference. In the last two decades Bellevue Hospital has reached a high point in its development as a teaching center, and the large sums of money appropriated made possible the complete modernization of this oldest of the municipal hospitals of New York City. The other institutions which are under the same board of trustees are Gouverneur, Harlem, Fordham and the Neponsit Beach Hospital for the treatment of bone, joint and gland tuberculosis in children from two to twelve years of age.

The Department of Public Welfare (formerly the Department of Charities) has under its jurisdiction the hospitals on Welfare (formerly Blackwell's) Island as well as the municipal hospitals in all the boroughs of the city except Manhattan and the Bronx. Recently the city acquired Lincoln Hospital, which was placed under the Department of Public Welfare. The new municipal hospital on 167th Street and Jerome Avenue, which was recently authorized by the city, has likewise been put under the charge of the Department of Public Welfare.

The three groups of hospitals maintained by the city are in no way correlated, either in administrative control or as to the division of the field of service, except that the Health Department hospitals deal exclusively with infectious diseases and that some of the hospitals of the Department of Public Welfare receive chronic patients, while those of the Bellevue and Allied Group are primarily and exclusively for acute conditions. There are no district limitations to the work of the municipal hospitals.

The Public Health Committee of the New York Academy of Medicine for many years has had under consideration the matter

of the consolidation of municipal hospitals. It has been pointed out that there is no more reason for three hospital departments than there would be for three police or fire departments. There is, however, a difference of opinion as to the contagious disease hospitals. As stated above, these hospitals are a part of the armamentarium of the Health Department. The department has certain police powers which at times it finds necessary to exercise with certain types of patients and which no other hospital group possesses or needs for its work. The Public Health Committee has felt that these are sufficiently weighty reasons for excluding the contagious disease hospitals from any consolidation plan.

When early in 1925 the mayor of the city and the commissioner of public welfare asked the opinion of the Committee as to the form the consolidation of the hospitals should take, the Committee developed a plan which affects all municipal hospitals, except those of the Department of Health. This plan has been presented in the form of a bill introduced in the Municipal Assembly by the mayor on December 11, 1925. Credit is due to former Senator Martin Saxe for the legal phraseology of the bill.

The bill in its tentative form provides for the transfer of the hospitals under the jurisdiction of the Board of Trustees of Bellevue and Allied Hospitals to that of the Department of Public Welfare. The question was considered whether the consolidated hospitals should be placed in a separate department of hospitals or into one of the existing departments. The recommendation favoring the close linking up of the hospitals with the other functions of the Department of Public Welfare was based on several considerations. The majority of the patients in the municipal hospitals are the "sick poor" who come under the tutelage of the Commissioner of Public Welfare as an overseer of the poor. The patients or their families are often in need of relief and social service guidance. Upon the Department devolves the care of the feebleminded, the chronics, the infirm and the aged. Many of these require more than merely custodial care. Through the hospitals a great deal of rehabilitation can be accomplished. Illness among the clientele of the Department is not a mere temporary incident in their life cycle. For these reasons it was thought

desirable that the hospitals should be made a part of the resources of the Department of Public Welfare.

The proposal of the Public Health Committee also provides that the ambulance service now under a special board should be made a part of the hospital system. It leaves undisturbed the status of the existing medical boards as well as of auxilliary committees on nursing and social service work, which are performing useful service in the hospitals.

The outstanding feature of the proposed plan is the Advisory Council which is endowed with important powers and duties concerning the medical, surgical, research and teaching policies of the hospitals. The Council of Eleven is to be appointed by the mayor from lists submitted to him by the five medical colleges of the city, the five county medical societies and the New York Academy of Medicine. The Council is to have a representative from each of these bodies. The Council will elect its own chairman and appoint an executive officer who will be responsible to the Council and whose salary will be paid by the city, the members of the Council not drawing any compensation for their work. The Council will pass on all the recommendations made to the commissioner by the respective medical boards of the hospitals with regard to the appointment of the visiting and resident medical staffs. It is thought that by this arrangement the management of the hospitals will be freed from such political pressure as is being occasionally exercised.

The Council will advise the commissioner with regard to the teaching procedures as well as to arrangements with medical schools and colleges. This plan will leave the commissioner free to devote his time to the development of administrative procedures and the social policies of the department. The bill provides for an extra deputy commissioner whose sole duty will be to supervise the administrative efficiency of the hospitals.

The Committee believes that this bill represents a step forward in the organization of the municipal hospitals. Before it is acted upon by the Municipal Assembly, several changes will be made in the present draft of the bill. The tenure of office of the members of the Advisory Council will be so arranged that only a few will go out of office annually, thus assuring to the Council continuity of policy. The legal provisions for safeguarding the

autonomy of the medical boards in the matter of appointments, the term of appointments, and other details of organization are under joint consideration by the Public Health Committee and representatives of the County Medical Societies. It is fully realized, however, that the proper working out of the plan will depend not so much on its detailed legal provisions as on the desire on the part of the mayor of the city and the Commissioner of Public Welfare to cooperate wholeheartedly with the Advisory Board in the promotion of the best interests of the sick in the City of New York.

E. H. L–C.

CANDIDATES RECOMMENDED TO FELLOWSHIP AT THE MEETINGS OF THE COMMITTEE ON ADMISSION HELD IN NOVEMBER AND DECEMBER, 1925

Armistead Cochran Crump, M.D.	20 West 50th Street
Robert Ogden DuBois, M.D.	125 East 94th Street
John Harry Garlock, M.D.	19 West 73d Street
Fairfax Hall, M.D.	Professional Building, New Rochelle
George DeWayne Hallett, M.D.	274 West 86th Street
Percy Klingenstein, M.D.	12 East 86th Street
Leila Charlton Knox, M.D.	St. Luke's Hospital
William Sargent Ladd, M.D.	254th Street & Independence Avenue
Hiram Ralph Leshin, M.D.	6 S. Main Street, Port Chester
John Marion Loré	244 West 71st Street
Jeremiah H. Metzger, M.D.	Tucson, Arizona
Anna Platt, M.D.	1140 Fifth Avenue
Saul Alfred Ritter, M.D.	161 West 80th Street
Herman Sharlit, M.D.	1090 St. Nicholas Avenue
Maximin De Mouy Touart, M.D.	30 West 70th Street
Joseph Storer Wheelwright, M.D.	62 East 55th Street
Bernard Langdon Wyatt, M.D.	123 S. Stone Avenue, Tucson, Arizona
And for Associate Fellowship:	
Hattie Louise Heft, M.S.	509 West 121st Street.

THE CHARCOT EXHIBIT

This year being the centenary of the great French neurologist Jean Martin Charcot, the Library wishes to add to the honors already given his memory and has placed on exhibition its collection of his writings.

The books and pamphlets were arranged in show cases grouped in the manner recorded below. The effect of the exhibit was greatly enhanced by the wall decoration of enlarged reproductions of portraits and busts taken from *Aesculape* for May, 1925, which were presented by Doctors Dana and McKendree.

Works by Charcot

Études pour servir à l'histoire de l'affection decrite sous les noms de goutte asthénique primitive, nodosités des jointures, rhumatisme articulaire chronique forme primitive, etc. Paris thèse, 1853.

Sur une forme particulière d'atrophie musculaire progressive . . . by Charcot and P. Marie. Revue de médecine, 1886, VI.

Description of "Charcot's Disease"

Article by Charcot and Robin in: Comptes rendus de la Société de biologie. 1853.

Charcot's Crystals

Leçons sur les maladies du système nerveux faites à la Salpêtrière. . . . Paris, 1872–3; 1875–77, 1880–85; 1884; 1877–87; 1892–93; 1892–94. 12 vols.

Leçons du mardi à la Salpêtrière. 2 vols. Paris, 1887–90.

Clinical lectures on diseases of the nervous system. Edition by Hurd. 1888.

Edition by Savill, 1889.

Lectures on diseases of the nervous system. By Comegys, 1881.

Edition by Sigerson, 1879.
" " " 1877.
" " " 1881.

Neue vorlesungen über die Krankheiten des Nervensystems. . . . Ausgabe von Sigmund Freud. 1886.

Lectures on the localization of cerebral and spinal diseases. . . . by W. B. Hadden. 1883.

Trans. by E. P. Fowler. 1878.

Ins Deutsche von Berthold. 1881.

Leçons cliniques sur les maladies des vieillards et les maladies chroniques. Paris, 1867.

Séries 2, 1867, 1868.

Édition 2, 1874.

Clinical lectures on senile and chronic diseases. Trans. by W. S. Tuke. London, 1881.

Trans. by L. H. Hunt. N. Y., 1881.

Lectures on Bright's disease of the kidneys. . . . Trans. by H. B. Millard. N. Y., 1878.

Leçons sur les conditions pathogéniques de l'albuminurie. Paris, 1881.

Sur la claudication intermittente observée dans un cas d'oblitération complète d'une des artères iliaques primitives. Repr: Gaz. méd. de Paris, 1859.

De la pneumonie chronique. Paris, 1860.

On the treatment by suspension of locomotor ataxia and some other spinal affections. . . . London, 1889.

De l'emploi de l'electricité statique en médecine. Repr: Rev. de médecine, 1881.

La foi qui guérit. Paris, 1897.

Oeuvres complètes. Paris, 1888–1890. 9 vols.

Charcot as Editor

Archives de physiologie (1868–93). 2 sample vols.

Archives de neurologie (1880–93). 2 sample vols.

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Exposé des titres du J. M. Charcot. Paris, 1866.

In Memoriam, etc.

J. M. Charcot. (Memorial biography.) Archives de neurologie, 1893.

Meige, H. Les effigies de Charcot. L'Aesculape, May, 1925.

Meige, H. Charcot artiste. Nouvelle iconographie de la Salpêtrière. 1898.

Naunyn, B. Jean Martin Charcot. Archiv für experimentelle Pathologie und Pharmakologie. 1894. v. 33.

Gilles de la Tourette. J. M. Charcot. Nouvelle iconographie de la Salpêtrière. 1893. v. 6.

Möbius, P. Zum andenken an Jean Martin Charcot. Repr: Münchener medicinische Wochenschrift. 1893.

Von Leyden, E. Jean Martin Charcot. Repr: Deutsche medicinische Wochenschrift. 1893.

Erb, W. H. Charcot. Leipzig, 1893.

Henderson, J. B. Personal reminiscences of M. Charcot. Glasgow medical journal. 1893. v. 40.

Hatch, F. F. M. Charcot, psychiatrist, clinician and scientist. Bulletin of the Massachusetts commission on mental diseases. Oct., 1918.

Garrison, F. H. The Charcot centenary. Bulletin of the New York Academy of Medicine. Nov., 1925.

Centenary of Charcot [Editorial]. Annals of medical history. 1925. P. 296.

Picture of La Salpêtrière in: Marthe, H. La Salpêtrière sous l'ancien régime.

COMMITTEE ON EXHIBITS

Comment has been made elsewhere in the BULLETIN on the exhibit of books by Sir Thomas Browne and also on the exhibit of publications of Jean Martin Charcot. A lively interest was taken in these exhibits by a number of Fellows of the Academy and acting upon a request of several of them, the Council has asked the President to appoint a special committee on exhibits. The following were appointed: Dr. C. N. B. Camac, *Chairman*; Dr. Rufus I. Cole, Dr. Karl Vogel and Dr. John Wyckoff.

It has been suggested that plans might be made for a series of exhibits not only on Historical Medicine but also on current medical topics and that as facilities would be available for their display in the new building, it would be highly desirable to prepare for them during the coming winter.

COMMITTEE ON CEREMONIES

The Council is advised by the Building Committee that if no unforeseen delays occur, the Academy should be able to move into the new building in the autumn.

The Council therefore authorized the President to appoint a committee on ceremonies connected with the opening of the new building. He has appointed the following committee:

Dr. Samuel A. Brown
Dr. C. N. B. Camac
Dr. Lewis A. Conner
Dr. William Darrach
Dr. Nellis B. Foster
Dr. Lewis F. Frissell
Dr. Emil Goetsch
Dr. Emanuel Libman
Dr. Howard Lilienthal
Dr. H. H. M. Lyle
Dr. Rufus I. Cole
Dr. George David Stewart
Dr. Walter Niles
Dr. Willy Meyer
Dr. Bernard S. Oppenheimer
Dr. Bernard Sachs
Dr. Fordyce St. John
Dr. Eugene H. Pool
Dr. Charles R. Stockard
Dr. James Ewing
Dr. W. Gilman Thompson
Dr. Paolo De Vecchi
Dr. Graham Lusk
Dr. Charles L. Dana
Dr. M. Allen Starr
Dr. Walter B. James

PORTRAIT OF JENNER

The Academy has just received a portrait of Edward Jenner which has been loaned by its owner, Mr. Samuel A. Sharpe, of New York. This portrait has never before been on public view.

The portrait is a small three quarter size bust, 17 by 14 inches, and is not in very good condition.

The portrait was painted by Mr. William Hobday, an artist of not very great renown, while he was visiting his nephew, a Mr. Davies, at Ebley House in 1821. The portrait has remained in the Davies family since that date and Mr. Sharpe is a direct descendant of the Davies family through the maternal side.

Those who are familiar with the well-known engraving of Jenner by Sharp and finished by William Skelton, who made such an excellent engraving of John Hunter, will recognize the portrait as the one from which this engraving was made.

There is a well-known portrait of Sir Edward Jenner in the National Gallery in London painted by Sir Thomas Lawrence, and there are also others by James Northcote and J. R. Smith and a less well-known portrait by J. Robinson.

LIBRARIAN

Dr. Archibald Malloch, Librarian of the Academy, returned from Europe on December 7, where he has been completing some research work in the Bodleian Library at Oxford.

During his stay, Dr. Malloch visited a number of book dealers in London and Paris in order to secure special numbers that were missing from our files of Journals and in order to make the acquaintance of certain officers connected with the Academy of Medicine of Paris, the Dean of the Faculty of Medicine of Paris, and also to visit the College of Physicians and the British Royal Medical Society in London.

Dr. Malloch began his duties as Librarian on January second.

FELLOWS ELECTED IN 1925

THE FOLLOWING IS A LIST OF THOSE ELECTED TO FELLOWSHIP IN THE ACADEMY IN 1925

Bell, Samuel Dennis
Berry, Frank Brown
Bohrer, John Verne
Boynton, Perry Sanborn
Carter, Rupert Franklin
Christensen, Frederick Carl
Coley, Bradley Lancaster
Collings, Clyde Wilson
Corwin, Edw. Henry Lewinski-
Cowett, Max Philip
Craver, Lloyd Freeman
Eller, Joseph Jordan
Ende, Frank Macbeth
Greenberg, David
Ginsberg, George
Graham, John Cooper
Hajek, Joseph
Haseltine, Sherwin Livingston
Hinton, James William
Hollander, Edward
Howard, Robert Carroll
Huppert, Elmer Isadore
Kempf, Edward John
Klepper, Julius Idel
Manheim, Sigmund
McIntosh, Rustin

Meyer, Herbert Willy
Mitchell, Wendell
Morrissey, John Henry
Myers, Lotta Wright
Randel, William Adonijah
Ratner, Bret
Reynolds, Frederick Pratt
Ritter, J. Sydney
Salzer, Benjamin
Scott, James Ralph
Seeeof, David Philip
Simpson, Charles Augustus
Sonnenschein, Harry David
Steiner, Joseph Manning
Stepita, Cornelius Travers
Tenny, Charles Frederick
Traub, Eugene Frederick
Von Sholly, Anna Irene
Washburn, Arthur Lawrence
Wiegel, Elmer Peter

RECENT ACCESSIONS TO THE LIBRARY

Association Suisse contre la tuberculose. IVme. conférence de l'Union internationale contre la tuberculose.
Lausanne. Ed. La concorde [1925?], 441 p.

Ballenger, W. L. Disease of the nose, throat and ear. 5. ed.
Phil. Lea & Febiger, 1925, 1080 p.

Bennet, T. I. The stomach and upper alimentary canal in health and disease.
London. Heinemann, 1925, 344 p.

Bigelow, R. P. Directions for the dissection of the cat.
N. Y. Macmillan, 1925, 57 p.

Bose, Y. M. Internal secretion in health and disease.
Calcutta. Butterworth, 1925, 550 p.

Botreau-Roussel. Ostéites pianiques: "gondou."
Paris. Masson, 1925, 129 p.

Bridges, J. W. An outline of abnormal psychology.
Columbus. Adams, 1925, 236 p.

Bush, D. V. How to put the subconscious mind to work . . .
Chic. Bush [1924], 459 p.

Ceni, C. Psiche e vita organica.
Milano. 1st. Edit. Sci. [1925], 250 p.

Cohen, J. B. & Ruston, A. G. Smoke. A study of town air.
London. Arnold, 1925, 108 p.

Curtis, G. W. Improved methods in hospital management.
Santa Barbara, Cal., Hosp. service exch., 1924, 176 p.

Dew, H. R. Malignant disease of the testicle . . .
London. Lewis, 1925, 168 p.

Dingwall, E. J. Male infibulation.
London. Bale, 1925, 145 p.

Dixon, W. E. A manual of pharmacology. 6. ed.
London. Arnold, 1925, 478 p.

Dreams and the interpretation of them. By a physician.
London. Palmer [1925], 112 p.

Drew, V. Mind, the healer.
London. Fowler [1925?], 208 p.

Dubreuil-Chambardel, L. Traité des variations du système artériel.
Paris. Masson, 1925, 271 p.

Dunham, F. L. An approach to social medicine.
Balt. Williams, 1925, 242 p.

Fehling, H. Entwicklung der Geburtshilfe und Gynäkologie im 19. Jahrhundert.
Berlin. Springer, 1925, 269 p.

Feinblatt, H. M. & Eggerth, A. H. Clinical laboratory medicine.
N. Y. Wood, 1925, 424 p.

Fischer, L. Diseases of infancy and childhood. 10. ed.
Phil. Davis, 1925, 2 vols.

Gerstmann, J. Die Malariabehandlung der progressiven Paralyse.
Wien. J. Springer, 1925, 229 p.

Great Britain. The statutes, regulations and orders relating to national health insurance.
London. H. M. Sta. Off. [1925], 709 p.

Groedel, F. M. Die physikalische Therapie der Herz- Gefäss- und Zirkulationsstörungen.
Berlin. Springer, 1925, 111 p.

Guaccero, A. Piedi torti.
Bari. Stab. Tip. Ed. Barese, 1925, 174 p.

Handbuch der normalen und pathologischen Physiologie . . . v. 2. Atmung, by K. Amersbach, G. Bayer [et al.].
Berlin. J. Springer, 1925. v. 2.

Harris, F. S. Scientific research and human welfare . . .
N. Y. Macmillan co., 1924, 406 p.

Harris, F. S. & Butt, N. I. The fruits of Mormonism.
N. Y. Macmillan, 1925, 146 p.

Hart, I. B. The mechanical investigations of Leonardo da Vinci.
Chic. Open Court pub. co., 1925, 240 p.

Health in childhood. Five lectures delivered at the Institute of Hygiene.
London. Bell, 1925, 94 p.

Holfelder, H.Atlas von Körperdurchschnitten für die Anwendung in der Röntgentiefentherapie.
Berlin. Springer, 1924, 38 p. (text), 38 pl. (atlas).

Hutchins, M.; Johnson, A. S. & Williams, M. S. Guide to the use of libraries. 3. ed.
N. Y. H. W. Wilson co., 1925, 251 p.

Index (An) of treatment by various writers. 9. ed.
Bristol. J. Wright & sons, 1925, 1035 p.

Janet, P. M. F. Psychological healing . . .
N. Y. Macmillan, 1925, 2 v.

Jenness-Miller, A. Get well—Keep well—Learn how.
London. Methuen [1925], 93 p.

Joad, C. E. M. Mind and matter.
London. Nisbet [1925?], 170 p.

Keith, A. The engines of the human body. 2. ed.
London. Williams, 1925, 343 p.

Kellogg, J. H. The new method in diabetes. 3. ed.
Battle Creek. Mod. med. pub. co., 1925, 300 p.

Klinik (Die) der bösartigen Geschwülste . . . Hrsg. von P. Zweifel & E. Payr.
Leipzig. Hirzel, 1924, v. 2.

Kommission für den Gesamtkatalog der Wiegendrucke. Gesamtkatalog der Wiegendrucke. v. 1.
Leipzig. Hiersemann, 1925, 682 p.

Kopetzky, S. J. Otologic surgery.
N. Y. Hoeber, 1925, 539 p.

Krabbe, K. H. Les maladies des glandes endocrines.
Paris. Le François, 1925, 92 p.

Labbé, M. Le traitement du diabète.
Paris. Masson, 1925, 152 p.

Leclerc, H. Le fruits de France.
Paris. Masson, 1925, 274 p.

LeGro, A. L. Ceramics in dentistry.
Brooklyn. Dent. Items of Interest, 1925, 263 p.

Lerebouillet, P. Les syndromes hypophysaires et épiphysaires en clinique infantile.
Paris. Baillière, 1924, 138 p.

Levene, P. A. T. Hexosamines and mucroproteins.
London. Longmans, 1925, 163 p.

Leveuf, J.; Girode, C.; Mornard, P. & Monod, R. Traitement des fractures et luxations des membres.
Paris. Masson, 1925, 464 p.

Lilienthal, H. Thoracic surgery.
Phil . . . Saunders, 1925, 2 v. 8′.

Locy, W. A. The growth of biology . . .
N. Y. Holt, 1925, 481 p.

Lorenzini, J. Théorie des vitamines et ses applications.
Paris. Masson, 1925, 88 p.

Mackenzie, F. Drugs the main cause of cancer.
London. Health promotion [1924?], 182 p.

McKillop, M. Food values. 3. ed.
London. Routledge, 1925, 152 p.

McMillan, M. Massage and therapeutic exercise. 2. ed.
Phil. Saunders [1925], 331 p.

Mandl, F. Chirurgie der Sportunfälle . . .
Berlin . . . Urban . . . 1925, 303 p.

Marston, M. Sir Edwin Chadwick (1800–1890).
London. Parsons [1925], 186 p.

Masters, D. The conquest of disease.
London. Lane [1925], 314 p.

Matthews, A. P. Physiological chemistry. 4. ed.
N. Y. Wood, 1925, 1233 p.

Midwifery, by ten teachers, under the direction of Comyns Berkeley. 3. ed.
London. Arnold, 1925, 778 p.

Mottram, V. H. Food and the family.
London. Nisbet [1925], 240 p.

Mracek, F. Mracek-Jesionek Atlas und Grundriss der Hautkrankheiten. 5. Aufl.
München. J. F. Lehmann, 1924, 260 p.

Munk, F. Pathologie und Klinik der Nierenerkrankungen. 2. Aufl.
Berlin. Urban . . . 1925, 661 p.

Nakano, H. Atlas der Harnsteine.
Leipzig. Deuticke, 1925, 45 p.

Nevin, M. & Puterbaugh, P. G. Conduction, infiltration and general anaesthesia in dentistry. 2. ed.
Brooklyn. Dent. Items of Interest, 1924, 360 p.

Noeggerath, C. & Eckstein, A. Die Urogenitalerkrankungen der Kinder.
Leipzig. Vogel, 1925, 245 p.

Pearl, R. The biology of popular growth.
N. Y. Knopf, 1925, 260 p.

Pettibone, C. J. V. An intermediate textbook of physiological chemistry with experiments. 3. ed.
St. Louis. Mosby, 1925, 404 p.

Reyburn, H. A. An introduction to psychology.
London. Harrap [1925], 324 p.

Rhinehart, S. M. The commonsense of health.
N. Y. Doran [1924], 307 p.

Rockefeller foundation. Div. of medical education. Methods and problems of medical education. 3. ser.
N. Y. Rockefeller found., 1925, 242 p.

Rogers, F. R. Physical capacity tests in the administration of physical education.
N. Y. Teachers College, 1925, 93 p.

Rout, E. A. Sex and exercise.
London. Heinemann, 1925, 97 p.

Saint Thomas's hospital reports. Vol. XLVII.
London. Adlard, 1925, 221 p.

Sanarelli, G. Nuove vedute sulle infezioni dell'apparato digerente.
Roma. Pozzi [1925], 181 p.

Sever, J. W. The principles of orthopedic surgery for nurses.
N. Y. Macmillan co., 1925, 203 p.

Sever, J. W. Textbook of orthopedic surgery.
N. Y. Macmillan, 1925, 353 p.

Singer, C. The evolution of anatomy.
London. K. Paul . . . 1925, 209 p.

Snow, C. M. The arithmetic of pharmacy.
London. Kimpton, 1925, 125 p.

Stock, A. The structure of atoms . . . Trans. from the 2. German ed. by S. Sugden.
N. Y. Dutton [1925?], 88 p.

Stopes, M. C. "The first five thousand."
London. J. Bale [1925], 67 p.

Stratz, C. H. Die Schönheit des weiblichen Körpers. 40. Aufl.
Stuttgart. Enke, 1925, 508 p.

Strohl, A. La conductibilité électrique du corps humain.
Paris. Masson, 1925, 130 p.

Stuart, E. What must I do to get well? 32. ed.
London. Simpkin, 1925, 358 p.

Taddei, D. Conferenze, lenzioni e note di chirurgia pratica . . .
Pisa. Arti Graf. Nistri, 1925, 428 p.

Thornton, E. Q. A medical formulary. 12. ed.
Phil. Lea, 1925, 352 p.

Tidy, H. L. A synopsis of medicine. 4. ed.
Bristol. Wright, 1925, 1000 p.

Tipton, E. S. Reducing menus for the hostess of today.
N. Y. . . . Appleton, 1925, 68 p.

Transactions of the Assurance medical society, London, for 1922 & 1923.
London, 1924, 211 p.

Turpin, R. A. La tétanie infantile.
Paris. Masson, 1925, 223 p.

U. S. Dep. of commerce. Bur. of the census. Manual of the international list of causes of death. Based on the 3. decennial revision . . . 1920.
Wash. Gov. pr. off., 1924, 302 p.

U. S. War dep. Surgeon general's office. The medical department of the United States army in the World War. V. 15, pt. 2. Medical and casualty statistics, by A. G. Love.
Wash. Gov. pr. off., 1925, 1368 p.

Wakeley, C. P. G. Aids to surgical diagnosis.
London. Baillière, 1925, 170 p.

Wang, C. Y. Handbook of pathology.
London. Bale, 1925, 513 p.

Weil, P. E. & Isch-Wall, P. La transfusion du sang.
Paris. Masson, 1925, 247 p.

Weinzierl, E. Die uneheliche Mutterschaft.
Berlin. Urban . . . 1925, 79 p.

Wells, H. G. Chemical pathology. 5. ed.
Phila. Saunders [1925], 790 p.

Wereschinski, A. Beiträge zur Morphologie und Histogenese der intraperitonealen Verwachsungen.
Leipzig. Vogel, 1925, 134 p.

Woodhead (Sir), G. G.; Albutt (Sir), C. & Jones, P. C. V. Papworth: administrative & economic problems in tuberculosis.
Cambridge. Univ. Pr., 1925, 63 p.

DEATHS OF FELLOWS OF THE ACADEMY

George French Little, 1104 East 4th Street, Brooklyn, N. Y.; born in Brooklyn, N. Y., July 11, 1865; graduated in medicine from Columbia University, College of Physicians and Surgeons, New York City, 1895; elected a Fellow of the Academy October 7, 1915; died December 5, 1925. Dr. Little was a Fellow of the American Medical Association, Fellow of the American College of Physicians, member of the American Society for the Prevention of Infant Mortality, member of the Pediatric Society, and member of the Pathological Society. He was senior visiting pediatrician at Kings County Hospital, consulting pediatrician at Mercy and Hempstead Hospitals, and Brooklyn Children's Aid Society.

Nathan Edwin Brill, M.D., A.M., 48 West 76th Street, New York City; born in New York City, January 13, 1860; graduated in Medicine from New York University in 1880; elected a Fellow of the Academy February 3, 1887; died December 13, 1925. Dr. Brill was a Fellow of the American Medical Association, a member of the American Society of Physicians, a member of the National Tuberculosis Association, a member of the American Neurological Society, a member of the American Society for the Advancement of Science, a member of the American Cancer Research Society, a member of the American Public Health Association, a member of the Pathological and Neurological Societies, and a member of the Society of Alumni of Bellevue

Hospital. He was consulting physician at Mt. Sinai Hospital and was one of the Trustees of the New York Academy of Medicine.

A more extended notice will be published in a later issue.

William Emery Studdiford

Dr. William Emery Studdiford was born July 4th, 1867, at Trenton, New Jersey. He was the son of the Rev. Samuel Miller and Mary Christina (née Emery) Studdiford, of Trenton, New Jersey.

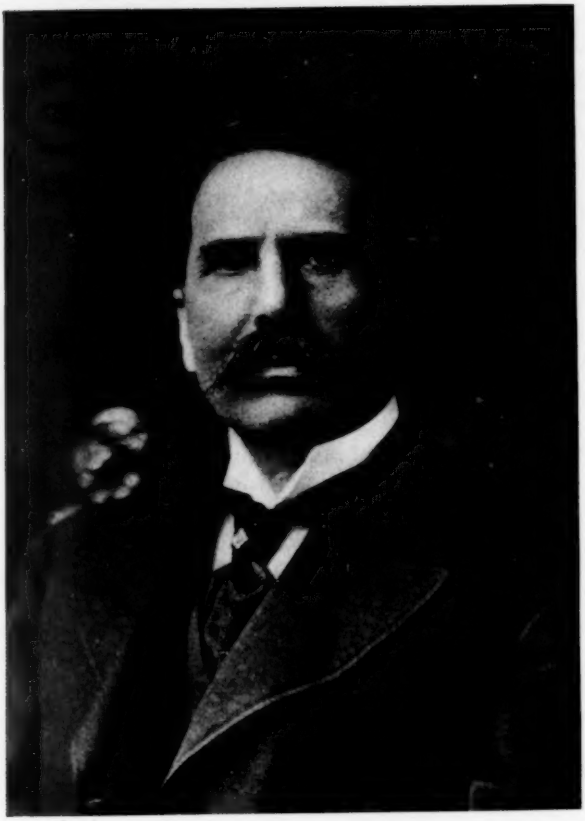
He was a graduate of Princeton University, A.B., 1888.

He graduated in medicine at the Bellevue Hospital Medical College in 1891. He received the degree of M.A. from Princeton in 1891. He served as an interne on the Third Medical Division of Bellevue Hospital, which included the gynecological service, in the years 1891 and 1892. In 1895 he was appointed assistant visiting gynecological surgeon to Bellevue Hospital, where he served under the late Dr. William T. Lusk until 1897 and afterward under Dr. Henry C. Coe until 1914. He was visiting gynecologist to Bellevue Hospital from 1914–1919 and on uniting the three gynecological divisions of that hospital into one, he was made chief of the service. From 1894 to 1899 he was assistant attending obstetrician to the Lying-in Hospital. He was professor of gynecology at the New York University and Bellevue Hospital Medical College from 1914 to 1919. He was appointed professor of obstetrics and gynecology at the College of Physicians and Surgeons of this City, and director of the Sloane Maternity Hospital in July, 1919, which positions he filled up to the time of his death.

He was a member of the Princeton, University and Century Clubs. He was a member of the Gynecological Club of America, of the American Medical Association, of the New York Academy of Medicine, and a Fellow of the American Gynecological Society and of the American College of Surgeons.

Studdiford's natural endowment peculiarly fitted him for his profession.

Socially he was kindly and considerate, sympathetic and thoughtful. He was tolerant and forbearing except with untruth



EDWARD BENNET BRONSON

and falseness. None ever came to him asking help and turned away unaided.

With his time and his strength he was prodigal in giving. With his money he gave daily what he could perhaps ill afford.

He had a rare gift for friendship and companionship and in friendship he was loyal and devoted perhaps to a fault.

In his professional work he was singularly original and resourceful. He permitted no clinical observation to go unexplained. He was content with no explanation which was inadequate or would not stand the test of experience. The rare quality of his work in preparation for operation; in his plastic work in the vagina both primary and secondary; his rather remarkable theories of the influence and function of the fascial planes of the pelvis are characteristic of all his work.

Finally, the simple dignity of the man gave a touch almost of grandeur to his presence in the operating room and by the bedside.

Edward Bennet Bronson

Edward Bennet Bronson, a dermatologist of international reputation, died suddenly at his home in New York City, November 18, 1925. He was born in Hartford, Conn., in 1843, of an old and highly respected New England family. His father, Thomas Bronson, his grandfather Bennet Bronson, two uncles, and numerous other male relatives were graduates of Yale College. Several of them were physicians.

Dr. Edward B. Bronson himself graduated from Yale in 1865. After studying a year at the Yale School of Medicine during '65 and '66, he entered the College of Physicians and Surgeons, New York, where he received the degree of M.D. in 1869. After serving an interneship in Bellevue Hospital he went abroad and continued his medical studies in Berlin, Dresden, Prague, Vienna, Paris, and London, paying especial attention to diseases of the skin. He returned to this country in 1872 and, settling in New York, entered with great earnestness upon the practice of his specialty, soon distinguishing himself as practitioner, writer, and lecturer.

He served as assistant surgeon to the New York Eye and Ear Infirmary, visiting surgeon to the New York Dispensary, visiting

physician to the City and Charity Hospitals, and the House of Mercy, attending surgeon and consulting physician to the Out-Door Poor Department of Bellevue Hospital, attending physician to the Northern Dispensary, consulting physician to the Babies' Hospital, and pathologist to the Metropolitan Throat Hospital. He was appointed professor of dermatology at the New York Polyclinic Medical School and Hospital in 1882, at the founding of that institution, and lectured regularly until 1904, when he became professor emeritus.

Dr. Bronson was an accomplished and valuable contributor to the department of dermatology, his articles appearing in the *Medical Press and Circular of London,* the *American Journal of Syphilis and Dermatology,* and in various other standard medical journals. He was a collaborator on the *Archives of Dermatology,* a member of the editorial staff of the *New York Medical Record,* and one of the translators of *Ziemssen's Encyclopedia of the Practice of Medicine.* He was a man of wide general reading, of liberal culture, and of a most genial disposition,—modest, dignified, and of great gentleness and purity of character. Although of small stature, his figure was particularly well proportioned and athletic. He was an ardent lover of certain forms of outdoor sports, a fine horseman, and, as a member of the New York Canoe Club, remarkably expert in sailing, especially so in the handling of a Rob Roy canoe.

He was a member of the Century, University and the Yale Clubs, of New York City. He never married.

By his death, tragically brought about through the fire which visited his home, there has been lost an accomplished master of his profession, a man of unusual refinement of mind and character, who throughout a long lifetime has exemplified the best traditions of his profession and people.

TABLE OF CONTENTS

The destruction of the quarantine station on Staten Island in 1858: FIELDING H. GARRISON 1

Anniversary discourse:

The doctor and the changing order: GEORGE E. VINCENT 6

Present status of chronic cholecystic disease, and practical aspects of studies in liver function: GEORGE B. EUSTERMAN 14

End results of tonsillectomy with special reference to the legal responsibility: THOMAS J. HARRIS 20

Proposed changes in the Constitution and By-laws of The New York Academy of Medicine 22

Public Health Committee:

Consolidation of municipal hospitals 26

Committee on Admission:

Candidates recommended for election to Fellowship 30

Notes:

The Charcot Exhibit 31

Appointment of a Committee on Exhibits 33

Appointment of a Committee on Ceremonies 34

Portrait of Jenner 34

Librarian 35

Fellows elected to Fellowship in 1925 35

Recent accessions 36

Deaths of Fellows of the Academy 42